VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 28, 2017

Ms. Cathy Etheze, Manager
Kingdom Way
Po Box 71
Newport, VT 05855

Dear Ms. Etheze:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on August 22, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

DEC - 1 2017

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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0295	A. BUILDING: _____ B. WING _____	C 08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGDOM WAY GROUP HOME	PO BOX 71 NEWPORT, VT 05855

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R100	Initial Comments: An unannounced onsite re-licensing survey and an anonymous complaint investigation were conduced by the Division of Licensing and Protection on 8/21/17 through 8/22/17. The findings include the following:	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct the state mandated assessment for 1 of 3 applicable residents, at the time of a condition change (Resident #3). The findings include the following: Per medical record review, Resident #3 was hospitalized for 3 days, then readmitted to the facility with a diagnosis of Hepatitis/Altered Mental Status. On 10/17/16 a new diagnosis of Cholangial Carcinoma was identified. Resident #3 was placed on Hospice Care and remained in the facility. The resident passed away on 11/16/16. Per review of the medical record, the last state mandated assessment completed was on 1/8/16 and signed as completed by the Registered Nurse (RN). This was confirmed by the manager at approximately 4 PM on 8/21/17	R136	See attachment	

R136 - R302 POC's accepted 12/6/17 mmcleod

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R136	Continued From page 1 and by the RN on 8/22/17 at 9:30 AM.	R136		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility Registered Nurse (RN) failed to ensure that a written plan of care was developed for 2 of 3 sampled residents identifying the care and services necessary for Resident #1 and #3 to maintain their well-being. The findings include the following: 1. Per observation on 8/21/17, Resident #1 sitting in a recliner in the living room at approximately 12 noon. Nurse surveyor identified a pea sized scab on the resident's right ear outer auricle. The surrounding tissue was bright red and warm to touch. The manager confirms that there are no orders for treatment of this ear wound. The resident also has 2 new pressure ulcers. Per interview with the RN on 8/22/17 at approximately 10 AM confirmation is made that the care plan has not been updated since August 2017 to reflect the two (2) sacral pressure ulcers	R145	See attachment	

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R145	Continued From page 2 or the scab located on the resident's outer right ear. 2. Per review of the medical record, Resident #3 was hospitalized for 3 days, then readmitted to the facility with a diagnosis of Hepatitis/Altered Mental Status. On 10/17/16 a new diagnosis of Cholangial Carcinoma was identified. Resident #3 was placed on Hospice Care and remained in the facility. The resident passed away on 11/16/16. Per review of the medical record, the RN last updated and signed the resident's care plan on 9/26/16. The plan of care does not include the change in the resident's condition, the need for Hospice Services and/or the collaboration between the two providers. This was confirmed by the manager at approximately 4 PM on 8/21/17 and by the RN on 8/22/17 at 9:30 AM.	R145		
R153 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility has failed to monitor the stability of resident weights for 5 of 7 sampled residents (Resident #1, #4, #5, #6 and #7). The findings include the following: Resident #1 was admitted to the facility on 4/17/17 and has not been weighed; Resident #4 was weighed 8/15/16 at 148.3	R153	See attachment	

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R153	Continued From page 3 pounds and on 2/17/17 at 147.4 pounds (not weighed for approximately 6 months); Resident #5 was weighed on 10/28/16 at 262.2 pounds and on 2/19/17 at 272 pounds (a 10-pound weight gain in 3+ months); Resident #6 was weighed on 3/11/15 at 157 pounds and has not had any further weights obtained; Resident #7 was weighed on 3/11/15 at 93 pounds and has not had any further weights obtained. Per review of the medical records and interview with both the facility manger and the case manager on 8/22/17 at approximately 9:30 AM, confirmation was made that weights are conducted at the physician's office during an office visit. Weights are not monitored in the facility because the current scale needs calibration.	R153		
R160 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission.	R160	See attachment	

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R160	Continued From page 4 (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to develop a policy and procedure for monitoring for side effects for 1 of 3 residents, who receive psychoactive medications. For Resident #1 the findings include the following: Per record review, Resident #1 has received Seroquel since 5/8/17 and Zyprexa since 4/2/14. Both medications are classified as antipsychotic medications used to treat Schizophrenia, Bipolar Disorder, Dementia and Depression. Side effects that can be caused using this medication are, but not limited to muscle and nerve problems and Tardive Dyskinesia (a disorder that results in involuntary body movements). Per review of physician, psychiatrist and nurses progress notes, there is no evidence that the resident has been evaluated for side effects from	R160		

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R160	Continued From page 5 the antipsychotic medications. This is confirmed by the manager on 8/21/17 at approximately 11:30 AM. The facility Registered Nurse also confirms on 8/22/17 at approximately 10 AM that there is no evidence that the resident has been screened for side effects from the use of psychoactive medications. All staff confirm that there is no policy directing staff on the monitoring of side effects for residents who receive psychoactive medications. See also R171.	R160		
R161 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility manager failed to ensure that discontinued medications are destroyed promptly. Per mediation room inspection on 8/21/17 at 10:07 AM, the following medications were found in a separate metal container in need of destruction: Resident #1 had a bingo card containing 30 tablets of Ativan 2 mg. and a second bingo card containing 20 tablets of Ativan 2 mg., a bingo	R161	See attachment	

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R161	Continued From page 6 card containing 4 capsules of Dronabinol 2.5 mg. and a bottle containing 7 tablets of Prednisone 10 mg. Per facility policy slide #42 directs staff, "If there needs to be any disposal of a controlled /other type of medications, they should be given to a nurse or supervisor. The medication will be destroyed in kitty litter and water with two nurses counting and destroying". The manager confirmed at the time of the inspection that the medications need to be destroyed.	R161		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects.	R171	See attachment	

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R171	Continued From page 7 (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to monitor 1 of 3 sampled residents who receive psychoactive medications. For Resident #1 the findings include the following: Per record review, Resident #1 has received Seroquel since 5/8/17 and Zyprexa since 4/2/14. Both medications are classified as antipsychotic medication used to treat Schizophrenia, Bipolar Disorder, Dementia and Depression. Side effects that can be caused using this medication are (not limited to) muscle and nerve problems and Tardive Dyskinesia (a disorder that results in involuntary body movements). Per review of physician, psychiatrist and nurses progress notes, there is no evidence that the resident has been evaluated for side effects from the antipsychotic medications. This is confirmed by the manager on 8/21/17 at approximately 11:30 am. The facility Registered Nurse also confirms on 8/22/17 at approximately 10 AM that there is no evidence that the resident has been screened for side effects from the use of psychoactive medications.	R171		
R177 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h	R177	See attachment	

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R177	Continued From page 8 (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and confirmed by staff interview the facility failed to keep narcotics and other controlled substances in a locked cabinet, and stored in the medication room. The findings include the following: Per mediation room inspection on 8/21/17 at 10:07 AM, the following controlled substances were in resident specific compartments (cubby-hole) that are not locked: Resident #5 has a cubby-hole that stored 3 tablets of Ativan 0.5 milligrams (mg.); Resident #1 has a cubby-hole that stored a bingo card containing 15 tablets of Clonazepam 0.5 mg and a second bingo card containing 27 tablets, a Hospice Kit that identified "Keep Refrigerated" that included Morphine Liquid multi-dose bottle 100 mg. per 5 millimeters (ml.) that was unopened, and 10 tablets of Ativan 0.5 mg... Haldol, Hyoscymine and Prochloper were also present in the kit, but are not controlled substances. The kit was not refrigerated as indicated; Resident #7 has a cubby-hole that stored a bingo card containing 8 tablets of Ativan 0.5 mg. and a second bingo card containing 30 tablets; Resident #2 has a cubby-hole that stored a bingo	R177		

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R177	Continued From page 9 card containing 16 tablets of Ativan 1 mg. Interview with the manager during the inspection confirmed that the locks on the cabinet doors are broken and in need of repair.	R177		
R221 SS=A	VI. RESIDENTS' RIGHTS 6.9 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to ensure that a written request was obtained to manage personal finances for 1 of 3 sampled residents (Resident #1). The findings include the following: Resident #1 was admitted on 4/17/17 who has an identified guardian. Resident #1's financial record has no evidence of a signed written request by guardian for the facility to manage the resident's personal funds. Confirmation was made by the Case Manager on 8/21/17 at 11:30 AM that a written request was never obtained.	R221	See attachment	

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R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to store foods in the dry storage area to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. The findings include the following: Per kitchen tour in the presence of the facility manager on 8/21/17 at approximately 9:45 AM, the cabinets storing dry goods were unprotected. 7 boxes of assorted dry cereal open, partially used, not sealed or dated as to when they were put in use; 32-ounce box of Buttermilk Pancake mix open, partially used, not sealed or dated as to when it was put in use; 2 sleeves of saltine crackers both open and partially used, not sealed or dated as to when they were put in use; 3 bags of assorted chips/pretzels/cheese puffs open, partially used, not sealed or dated as to when they were put in use; 2 five-pound bags of flour and 1 five-pound bag of sugar open, partially used, not sealed or dated as	R251	See attachment	

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R251	Continued From page 11 to when they were put in use; 1-ounce box of baking soda open, partially used, not sealed or dated as to when it was put in use. Per discussion with the manager at the time of the tour, confirmation was made that the above information was found and food items should have been sealed and dated. The manager also confirms that they have always discarded food if the date put in use is longer than 3 days.	R251		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that hot water temperatures did not exceed 120 degrees Fahrenheit in one shared resident bathroom and the kitchen sink that is accessible to all. The findings include the following: During the initial facility tour on 8/21/17 at approximately 9:30 AM a common used bathroom at the end of the hall located across from Room #4 had hot water temperature that registered 124 degrees from the sink. Kitchen sink that is available to all staff/residents/visitors had a hot water temperature that registered 127 degrees. On 8/21/17 at 4:30 PM: A common used	R291	See attachment	

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R291	Continued From page 12 bathroom at the end of the hall located across from Room #4 had hot water temperature that barely registered 96 degrees at the sink; The kitchen sink that is available to all staff/residents/visitors had a hot water temperature that registered 124-126 degrees. On 8/22/17 at 7:30 AM: A common used bathroom at the end of the hall located across from Room #4 had hot water temperature that registered 122-126 degrees at the sink; The kitchen sink that is available to staff/residents/visitors had a hot water temperature that registered 123-124 degrees. The above temperatures were confirmed by the manager on both days in the AM and PM. The manager also confirms the water temperatures are checked daily, but are not logged. A plumber was contacted immediately.	R291		
R302 SS=C	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	R302	See attachment	

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KINGDOM WAY GROUP HOME	PO BOX 71 NEWPORT, VT 05855

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R302	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility failed to ensure that quarterly fire drills were conducted on the evening and night shifts. The findings include the following: Per interview with the facility manager and review of fire drill logs, identified that five (5) drills were conducted during the past year. The drills took place on 8/17/16 at 10 AM, 12/12/16 at 2:15 PM, 3/15/17 at 10 AM, 6/28/17 at 4 PM and 7/17/17 at 9:30 AM. The facility manager confirms on 8/21/17 at approximately 3 PM that no drills were conducted during the evening and night shifts.	R302		

Facility: Kingdom Way **Survey Date:** 8/21-8/22/2017

R136 – V. RESIDENT CARE AND HOME SERVICES
5.7. Assessment

Plan of Correction:

- The Residential Manager will notify the Registered Nurse when significant changes occur in a resident's physical or mental condition.
- The Registered Nurse will complete a new Resident Assessment to reflect the change in status.
- The licensee will provide additional oversight through intermittent audits of Resident Assessments
- Date corrective action implemented: Immediate

R145– V. RESIDENT CARE AND HOME SERVICES
5.9.c (2) Level of Care and Nursing Services

Plan of Correction:

- The Residential Manager will notify the Registered Nurse when significant changes occur in a resident's physical/mental condition and/or support needs.
- The Registered Nurse will complete a new Resident Assessment to reflect the change in status and a new plan of care will be completed if indicated.
- The licensee will provide additional oversight through intermittent audits of resident care plans.
- Date corrective action implemented: Immediate

R153 - V. RESIDENT CARE AND HOME SERVICES
5.9.c (10) Level of Care and Nursing Services

Plan of Correction:

- The home's wheelchair scale has been recalibrated and is functional.
- The Residential Manager will ensure that resident weights are obtained monthly or as indicated by the resident's physician or the nursing care plan. Residents on palliative care may be weighed less frequently if the process adversely impacts their level of comfort and/or as indicated by their physician.
- The Residential Manager will ensure that the weights (obtained either at the home or during an off-site medical appointment) are documented on a tracking sheet maintained in each resident's medical record.
- The Residential Manager and Registered Nurse will review documented weights and ensure that significant changes in weight are addressed.
- The licensee will provide additional oversight through periodic audits of resident charts.
- Date corrective action implemented: Immediate

R160 - V. RESIDENT CARE AND HOME SERVICES
5.10 Medication Management

Plan of Correction:

- The Residential Manager will continue to ensure that all residents who receive psychoactive medications are seen by the prescribing physician or psychiatrist on a quarterly basis.
- The Residential Manager will ensure that an AIMS test or comparable assessment is completed at least every six months or as otherwise indicated by the prescribing physician.
- The results of the screening or assessment will be documented either through inclusion in the clinician's progress note or on an appropriate screening tool (i.e. AIMS) and filed in the resident's medical record.
- The Registered Nurse will provide oversight through regular chart audits.
- The licensee will provide additional oversight through periodic chart audits.
- Date corrective action implemented: Immediate

R161 - V. RESIDENT CARE AND HOME SERVICES
5.10 Medication Management

Plan of Correction:

- The Residential Manager will ensure that all medications are handled, stored, and destroyed in accordance with the facility's policies.
- The Registered nurse will provide additional oversight by regularly monitoring the handling and security of the medication storage, and will destroy applicable medications in accordance with the facility's policies.
- The licensee will provide additional oversight through periodic inspection and records review
- Date corrective action implemented: Immediate

R171 - V. RESIDENT CARE AND HOME SERVICES
5.10 Medication Management

Plan of Correction:

- The Residential Manager will continue to ensure that all residents who receive psychoactive medications are seen by the prescribing physician or psychiatrist on a quarterly basis.
- The Residential Manager will ensure that an AIMS test or comparable assessment is completed at least every six months or as otherwise indicated by the prescribing physician.
- The results of the screening or assessment will be documented either through inclusion in the clinician's progress note or on an appropriate screening tool (i.e. AIMS) and filed in the resident's medical record.
- The Registered Nurse will provide oversight through regular chart audits.
- The licensee will provide additional oversight through periodic chart audits.
- Date corrective action implemented: Immediate

R177 - V. RESIDENT CARE AND HOME SERVICES
5.10 Medication Management

Plan of Correction:

- The Residential Manager will ensure that all medications are stored in a locked cabinet at all times. Any issues that limit the home's ability to secure the medications (i.e. broken lock) will be addressed promptly.
- The Registered nurse will provide additional oversight by regularly monitoring the security of the medication storage.
- The licensee will provide additional oversight through periodic inspection
- Date corrective action implemented: Immediate

R221 - VI. RESIDENT'S RIGHTS
6.9

Plan of Correction:

- The Residential Manager will ensure that resident/guardian requests for the home to manage the resident's finances are completed in writing.
- The licensee will provide oversight through periodic reviews of resident records.
- Date corrective action implemented: Corrected for identified resident; ongoing

R251 – VII. NUTRITION AND FOOD SERVICES
7.3 Food Storage and Equipment

Plan of Correction:

- The Residential Manager will continue to ensure that food and drink is stored in a manner that protects it from dust, insects, rodents, overhead leakage, unnecessary handling, and all other sources of contamination.
- The licensee will provide oversight through periodic review and inspection of facilities.
- Date corrective action implemented: Immediate and ongoing.

R291 – IX. PHYSICAL PLANT
9.6.d Plumbing

Plan of Correction:

- The immediate issue was corrected on the day of the survey
- The Residential Manager will ensure that the water temperatures are monitored and documented daily. Any future reoccurrences will be corrected immediately.
- Date corrective action implemented: Immediate and ongoing.

R302 – IX. PHYSICAL PLANT
9.11 Disaster and Emergency Preparedness

Plan of Correction:

- The Residential Manager will ensure that regular fire drills continue to be completed and will include those done on evening and night shifts.
- The licensee will provide oversight through periodic reviews of facility fire drill logs
- Date corrective action implemented: Immediate and ongoing.